for outliers and other factors as specified in § 412.525.

[67 FR 56049, Aug. 30, 2002, as amended at 68 FR 34162, June 6, 2003; 71 FR 27899, May 12, 2006]

§ 412.525 Adjustments to the Federal prospective payment.

(a) *Adjustments for high-cost outliers.* (1) CMS provides for an additional payment to a long-term care hospital if its estimated costs for a patient exceed the adjusted LTC-DRG payment plus a fixed-loss amount. For each long-term care hospital rate year, CMS determines a fixed-loss amount that is the maximum loss that a hospital can incur under the prospective payment system for a case with unusually high costs.

(2) The fixed-loss amount is determined for the long-term care hospital rate year using the LTC-DRG relative weights that are in effect on July 1 of the rate year.

(3) The additional payment equals 80 percent of the difference between the estimated cost of the patient's care (determined by multiplying the hospital-specific cost-to-charge ratio by the Medicare allowable covered charge) and the sum of the adjusted LTCH PPS Federal prospective payment and the fixed-loss amount.

(4)(i) For discharges occurring on or after October 1, 2002 and before August 8, 2003, no reconciliations will be made to outlier payments upon cost report settlement to account for differences between the estimated cost-to-charge ratio and the actual cost-to-charge ratio of the case.

(ii) For discharges occurring on or after August 8, 2003, and before October 1, 2006, high-cost outlier payments are subject to the provisions of § 412.84(i)(1), (i)(3), and (i)(4) and (m) for adjustments of cost-to-charge ratios.

(iii) For discharges occurring on or after October 1, 2003, and before October 1, 2006, high-cost outlier payments are subject to the provisions of § 412.84(i)(2) for adjustments to cost-to-charge ratios.

(iv) For discharges occurring on or after October 1, 2006, high-cost outlier payments are subject to the following provisions:

(A) CMS may specify an alternative to the cost-to-charge ratio otherwise applicable under paragraph (a)(4)(iv)(B) of this section. A hospital may also request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital. A request must be approved by the CMS Regional Office.

(B) The cost-to-charge ratio applied at the time a claim is processed is based on either the most recent settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period.

(C) The fiscal intermediary may use a statewide average cost-to-charge ratio, which CMS establishes annually, if it is unable to determine an accurate cost-to-charge ratio for a hospital in one of the following circumstances:

(*1*) A new hospital that has not yet submitted its first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18 of this chapter.)

(*2*) A hospital whose cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean cost-to-charge ratio. CMS establishes and publishes this mean annually.

(*3*) Any other hospital for which data to calculate a cost-to-charge ratio are not available.

(D) Any reconciliation of outlier payments is based on the cost-to-charge ratio calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

(E) At the time of any reconciliation under paragraph (a)(4)(iv)(D) of this section, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment is based upon a widely available index to be established in advance by the Secretary, and is applied from the midpoint of the cost reporting period to the date of reconciliation.

(b) *Adjustments for Alaska and Hawaii.* CMS adjusts the Federal prospective payment for the effects of a higher cost

of living for hospitals located in Alaska and Hawaii.

(c) *Adjustments for area levels.* The labor portion of a long-term care hospital's Federal prospective payment is adjusted to account for geographical differences in the area wage levels using an appropriate wage index (established by CMS), which reflects the relative level of hospital wages and wage-related costs in the geographic area (that is, urban or rural area as determined in accordance with paragraph (c)(1) or (c)(2) of this section) of the hospital compared to the national average level of hospital wages and wage-related costs. The appropriate wage index (established by CMS) is updated annually.

(1) For cost reporting periods beginning on or after October 1, 2002, with respect to discharges occurring during the period covered by such cost reports but before July 1, 2005, the application of the wage index under the long-term care hospital prospective payment system is made on the basis of the location of the facility in an urban or rural area as defined in §412.62(f)(1)(ii) and (f)(1)(iii), respectively.

(2) For discharges occurring on or after July 1, 2005, the application of the wage index under the long-term care hospital prospective payment system is made on the basis of the location of the facility in an urban or rural area as defined in §412.64(b)(1)(ii)(A) through (C).

(d) *Special payment provisions.* CMS adjusts the Federal prospective payment to account for—

(1) Short-stay outliers, as provided for in §412.529; and

(2) A 3-day or less interruption of a stay and a greater than 3-day interruption of a stay, as provided for in §412.531.

(3) Patients who are transferred to onsite providers and readmitted to a long-term care hospital, as provided for in §412.532.

(4) Long-term care hospitals-within-hospitals and satellites of long-term care hospitals as provided in §412.534.

[67 FR 56049, Aug. 30, 2002, as amended at 68 FR 34163, June 6, 2003; 68 FR 34515, June 9, 2003; 69 FR 25721, May 7, 2004; 70 FR 24222, May 6, 2005; 71 FR 48140, Aug. 18, 2006]

§412.529 Special payment provision for short-stay outliers.

(a) *Short-stay outlier defined.* ''Short-stay outlier'' means a discharge with a length of stay in a long-term care hospital that is up to and including five-sixths of the geometric average length of stay for each LTC-DRG.

(b) *Adjustment to payment.* CMS adjusts the hospital's Federal prospective payment to account for any case that is determined to be a short-stay outlier, as defined in paragraph (a) of this section, under the methodology specified in paragraph (c) of this section.

(c) *Method for determining the payment amount.* (1) For discharges from long-term care hospitals described under §412.23(e)(2)(i), occurring before July 1, 2006, the LTCH prospective payment system adjusted payment amount for a short-stay outlier case is the least of the following amounts:

(i) 120 percent of the LTC–DRG specific per diem amount determined under paragraph (d)(1) of this section;

(ii) 120 percent of the estimated cost of the case determined under paragraph (d)(2) of this section; or

(iii) The Federal prospective payment for the LTC–DRG determined under paragraph (d)(3) of this section.

(2) For discharges occurring on or after July 1, 2006, from long-term care hospitals described under §412.23(e)(2)(i), the LTCH prospective payment system adjusted payment amount for a short-stay outlier case is the least of the following amounts:

(i) 120 percent of the LTC–DRG specific per diem amount determined under paragraph (d)(1) of this section;

(ii) 100 percent of the estimated cost of the case determined under paragraph (d)(2) of this section;

(iii) The Federal prospective payment for the LTC–DRG as determined under paragraph (d)(3) of this section; or

(iv) An amount payable under subpart O computed as a blend of an amount comparable to the hospital inpatient prospective payment system per diem amount determined under paragraph (d)(4)(i) of this section and